BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **RICK J. GOMEZ, M.D.** Holder of License No. **33677** For the Practice of Allopathic Medicine In the State of Arizona.	**Case No. MD-13-0504A** **MD-13-0617A** **INTERIM FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR SUMMARY SUSPENSION OF LICENSE**

INTRODUCTION

The above-captioned matter came on for discussion before the Arizona Medical Board ("Board") at an emergency Board meeting on November 8, 2013. After reviewing relevant information and deliberating, the Board voted to consider proceedings for a summary action against the license of Rick J. Gomez, M.D. ("Respondent"). Having considered the information in the matter and being fully advised, the Board enters the following Interim Findings of Fact, Conclusions of Law and Order for Summary Restriction of License, pending formal hearings or other Board action. A.R.S. § 32-1451(D).

INTERIM FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 33677 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case numbers MD-13-0504A and MD-13-0671A after receiving a complaint that Respondent had submitted 24 claims billed for spinal injections (two of which were not supported by medical records), all of which were for date of service after the Board issued an Order prohibiting spinal injections on October 12, 2012,

followed by a Final Order for Letter of Reprimand and Practice Restriction dated April 3, 2013, that continued the prohibition on spinal injections.

4. The prohibitions on spinal injections occurred in Board case number MD-11-1582A, which the Board initiated after receiving a complaint regarding Respondent's care and treatment of a 30 year-old female patient ("JH"). The case was reviewed by a Medical Consultant (MC) to evaluate the medical records from a standard of care perspective.

5. The MC identified several deviations from the standard of care related to Respondent's performance of spinal injections.

6. On October 12, 2012, Respondent entered into an Interim Practice Restriction prohibiting him from performing spinal injections. On April 3, 2013, Respondent entered into a Consent Agreement for Letter of Reprimand and Practice Restriction ("Consent Agreement") prohibiting him from performing spinal injections and requiring him to obtain the services of a monitoring company to ensure compliance with the restriction.

7. The monitoring company retained by Respondent pursuant to the Consent Agreement issued a report to the Board based upon concerns it had regarding his compliance with the Board's order. The monitoring company noted that Respondent's documented physical examinations of the musculoskeletal system appeared to be appropriately focused, but the information recorded was the same for all of the charts reflecting patients who had a sacroiliac injection (SI); there was no documentation of SI disease. The monitoring company also found that he recorded minimal differentiating factors and these did not serve to provide additional diagnostic data. None of the patient files contained diagnostic or imaging studies.

8. According to the monitoring company, Respondent did not provide a clinical rationale for his diagnosis-the charts did not contain any mention of SI disease in the history or evaluation. In addition, the absence of imaging studies limited complete

understanding of the patient's problem. As a result, the monitoring company could not confirm Respondent's diagnostic accuracy.

9. The monitoring company found that Respondent's management consisted of anesthetic injections that he performed at the initial visit and subsequent follow-up visits in most cases. He injected the anesthetic into the SI joint. The monitoring company also noted that injections with anesthetic are usually performed as a diagnostic study and not to address pain. In addition, fluoroscopy is recommended to help guide the injection into the correct area.

10. The monitoring company concluded that Respondent's care was out of compliance with the Consent Agreement in those cases in which he performed SI injections during the period reviewed.

11. A Medical Consultant (MC) reviewed seven of 13 patient charts that were provided for review. Respondent failed to document procedures billed on multiple visits for multiple patients.

12. The MC found Respondent indicated in his Board staff interview that he made corrections to records more than two and a half years after the fact, and apparently after records were requested by Board staff. According to the MC's report, it appears that not all corrections were identified and dated, and the corrections were not timely.

13. The MC also found that in the case of one patient, he performed 27 bilateral sacroiliac joint injections over the course of 29 months. According to the MC, there is no legitimate diagnostic or therapeutic rationale to persist in essentially monthly injections of the same joints for over two years.

14. The MC found that in the case of one patient, nine bilateral sacroiliac injections included Toradol even though Toradol is approved for intramuscular use only and there is no accepted therapeutic role or adequate safety data for repeated injections

of Toradol into the knee or sacroiliac joints. Toradol is neurotoxic and to be avoided in injection procedures with the potential for intrathecal spread (for example facet injections).

15. In another case, the MC found that five consecutive intra-articular injections with Toradol were performed (a total of 300 mg Toradol injected intra-articularly over five months).

16. The MC also noted that patients were exposed to unnecessary invasive procedures, which could potentially be associated with complications to include increased pain, local anesthetic reaction, and infection.

17. The MC found it aggravating that Respondent does not acknowledge that sacroiliac joint injections are spinal injections, given the fact that he was instructed in the performance of these injections at a course for spinal procedures, and the certificate provided to him, specifies that "This course covered Cervical, Thoracic and Lumbar Spine Procedures".

18. The MC found it aggravating that Respondent continued sacroiliac joint injections but abandoned fluoroscopic guidance. Given that he attended a course in fluoroscopically guided spine injections, which included instruction in SI joint injections, it would be expected that he would have minimally taken away from that course the importance of fluoroscopy in performance of sacroiliac joint injections. (Studies have demonstrated that the failure rate in actually reaching the joint without imaging may be as high as 88%). Based upon his response that he understood that the Board Order prohibited the use of fluoroscopy, but not the injections, it appears that his decision to forego fluoroscopy for sacroiliac joint injection was not based on clinical judgment as to what was best for the patient.

19. In case MD-13-0617A, MD, a then 27 year old woman, established care with the licensee on October 07, 2010 for complaints of chronic back, neck and shoulder pain. Multiple pain diagnoses were made at the first visit to include migraines, fibromyalgia, cervicalgia, lumbago, sacroiliitis, bilateral shoulder and knee pain, degenerative disc disease, muscle spasm, radiculopathy and paresthesias. History of illicit drug use and alcoholism was obtained. #120 Oxycodone 15 mg and topamax were prescribed at the first visit.

20. #140 Oxycodone 15 mg was prescribed at each subsequent visit. There is no report of urine drug testing over the ten months that narcotic was prescribed. There is no documentation of CSPMP review. Topomax was continued and Robaxin added.

21. Following the initial evaluation, she was seen for nine subsequent visits over a nine month period between 11/09/10 and 8/11/11. At each visit, injections were performed. Although no written informed consent is in the records, prior to each injection procedure there is a notation that the risks and benefits were explained. Although reference is made to a lumbar MRI ordered 11/24/10, no MRI report is provided in the medical records.

22. On August 11, 2011 Respondent performed "bilateral scapular multiple trigger point injections" with 4mL 2% Lidocaine and 10 mg methylprednisolone. Immediately afterward, as MD was brought to an upright position, she reported feeling dizzy. The licensee auscultated the chest, estimating a heart rate of 60. She became unresponsive, and a carotid pulse and respirations could not be appreciated. EMT was called, and two person CPR initiated.

23. Per EMS report, MD was pulseless and apneic when they arrived. She was intubated, and administered epinephrine and Narcan in the office, prior to transportation by ambulance to the Emergency Department.

24. Upon arrival at the Emergency Department MD had a pulse but was still apneic. The accompanying boyfriend of MD provided history of MD's narcotic use to include Morphine and Valium, in addition to the Oxycodone prescribed by Dr. Gomez.

25. CSPMP query obtained at the hospital demonstrates multiple simultaneous prescribers of narcotic during the time that Dr. Gomez prescribed Oxycodone, as well as one prescriber of Diazepam.

26. MD was admitted to ICU and mechanically ventilated. Hospital course was complicated by status epilepticus, cerebral ischemia and possible aspiration pneumonia.

27. On September 7, 2011 she was transferred to a skilled nursing facility. According to the discharge note "the overall prognosis is extremely poor with chance of any meaningful recovery is almost nil".

28. A physician is reasonably expected to read and understand a Board order before he signs it and to comply with it after it is entered into.

29. Respondent repeatedly performed sacroiliac joint injections after entering into a Board order that prohibited from performing spinal injections.

30. Prior to performing any interventional pain procedure, there should be appropriate evaluation of the patient and judicious procedural selection for diagnostic or therapeutic purposes.

31. Respondent proceeded directly to sacroiliac joint injections in the absence of an adequate targeted physical exam, and without documentation of a reasoned, conservative approach to the suspected pain generator prior to performing invasive injections. There appears to be injudicious use of this injection technique.

32. Sacroiliac joint injections are performed for diagnostic and therapeutic purposes.

33. Respondent deviated from the above standard of care in the cases reviewed. For example, in the case of JS, he performed 27 bilateral sacroiliac joint injections over the course of 29 months. There is no legitimate diagnostic or therapeutic rationale to persist in essentially monthly injections of the same joints for over two years.

34. Toradol is approved for intramuscular use only. There is no accepted therapeutic role or adequate safety data for repeated injections of Toradol into the knee or sacroiliac joints.

35. In the case of JS, nine bilateral sacroiliac injections by Respondent included Toradol. Respondent also included Toradol in a facet joint injection. In the case of BC, five consecutive intra-articular injections with Toradol were performed (a total of 300 mg Toradol injected intra-articularly over five months).

36. Intra-articular injections of steroid into the knee, ankle or other large joints should be preceded by targeted history, physical examination and imaging that support the reasonableness of a steroid injection for an inflammatory condition, as well as failure to respond to an adequate dose of NSAID (as tolerated).

37. In the case of BC, over a seven month period Respondent performed seven intra-articular injections of steroid (Kenalog 40 mg each time) to the left knee. There appears to be an absence of reasonable evaluation or assessment of response to treatment to warrant the initial and ongoing injections. The number of injections of steroid into the joint exceeds the maximum recommended. Similar deviation is identified in the multiple injections of steroid into the ankle joint in the case of patient CH (seven injections of steroid into the ankle over fourteen months)

38. Appropriate monitoring of compliance is indicated when prescribing narcotics for chronic pain. The level of such monitoring should include urine drug testing and CSPMP review when the patient has been identified as high risk for such prescribing.

39. There is no urine drug testing or documented CSPMP review, despite ten months of prescribing of narcotics to an individual with known history of polysubstance abuse and chaotic living environment which was documented by Respondent

40. The performance of interventional pain management to include spine related injections requires the immediate availability of monitoring and resuscitative equipment in the event of complications, up to and including cardiopulmonary arrest.

41. Respondent acknowledged that he does not have resuscitative equipment available in his office, despite his own report of having performed thousands of spine injections

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e)("[f]ailing or refusing to maintain adequate records on a patient.")

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

4. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter.")

1. Based on the foregoing Interim Findings of Fact and Conclusions of Law, the public health, safety or welfare imperatively requires emergency action. A.R.S. § 32-1451(D).

INTERIM ORDER

Based on the foregoing Interim Findings of Fact and Conclusions of Law, set forth above,

IT IS HEREBY ORDERED THAT:

1. Respondent's license to practice allopathic medicine in the State of Arizona, License No. 33677, is summarily suspended and he is prohibited from practicing medicine in the State of Arizona and is prohibited from prescribing any form of treatment including prescription medications or injections of any kind. The Board may require any combination of staff approved assessments, evaluations, treatments, examinations or interviews it finds necessary to assist in determining whether Physician is able to safely resume such practice.

2. The Interim Findings of Fact and Conclusions of Law constitute written notice to Respondent of the charges of unprofessional conduct made by the Board against him. Respondent is entitled to a formal hearing to defend these charges as expeditiously as possible after the issuance of this order.

3. The Board's Executive Director is instructed to refer this matter to the Office of Administrative Hearings for scheduling of an administrative hearing to be commenced as expeditiously as possible from the date of the issuance of this order, unless stipulated and agreed otherwise by Respondent.

DATED AND EFFECTIVE this 8th day of November, 2013.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Patricia E. McSorley
Interim Acting Executive Director

EXECUTED COPY of the foregoing mailed this 8th day of November, 2013 to:

Rick J. Gomez, M.D.
Address of Record

ORIGINAL of the foregoing filed this 8th day of November, 2013 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

Mary Baker
Arizona Medical Board Staff